TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bone & Joint Clinic of Houston

Respondent Name
Petroleum Casualty Co

MFDR Tracking Number
M4-16-1307-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received an original denial stating that the services rendered were included with another service or procedure. We appealed that denial stating that even though the left wrist underwent surgery and would be in global period, the doctor also treated the right wrist on this day, hence the reason we used the modifier 24."

Amount in Dispute: $257.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains that final action for date of service 05/20/2015 was rendered in accordance with DWC adopted medical fee guideline and Medicare payment policies in effect at the time services were provided. The E/M visit that occurred on 5/20/15 was indeed a post-op visit for BOTH surgical procedures that occurred on 5/13/15 and the visit falls under the global policy and is not subject to reimbursement."

Response submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2015	99213, -24	$257.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - R13 – Visit falls within a surgery follow-up period
   - 236 – This proc or proc/mod combo not compatible w/another proc on same day

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code R13 – "Visit falls within a surgery follow-up period." 28 Texas Administrative Code §134.203 (b)(1) states,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   Review of the AMA CPT description for the service in dispute 99213 is - "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family." The requestor also indicated the "24" modifier or, "Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service."

   Review of the submitted medical documentation finds, "Physical Exam – Post operative Exam: General Appearance: wound clean and dry and appropriate range of motion. No sign of infection, no dehiscence, capillary refill less than 3 seconds sensation intact to radial/ulnar nerve distribution, Median nerve distribution sensation improving from preoperatively. Right hand – median nerve distribution sensation improved, 5 out of 5 strength, full range of motion." HPI – "The patient reports a numbness and tingling have resolved after the surgeon the left. The right hand is doing well after the injection also." Based on this information, the Division finds insufficient information to support the evaluation and management service was unrelated to the original procedure. The carrier's denial is supported.

2. Based on the requirements of Rule 134.203(b) no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.